STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	12/08/2011

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CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 5, 6, 7, and 8, 2011 Facility number: 000192 Provider number: 155295 AIM number: 100291120 Survey team: Toni Maley, BSW, TC Tammy Alley, RN DeAnn Mankell, RN Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 10 Medicaid: 52 Other: 11 Total: 73 Sample: 15 Supplemental sample: 13 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	*This Plan of Correction is the center'scredible allegation of compliance.Preparation and/or execution of this plan ofcorrection does not constitute admission oragreement by the provider of the truth of thefacts alleged or conclusions set forth in thestatement of deficiencies. The plan ofcorrection is prepared and/or executed solelybecause it is required by the provisions offederal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0151 SS=D	Quality review 12/14/11 by Suzanne Williams, RN The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. Based on observation , interview and record review, the facility failed to ensure residents were given the choice to open their room windows for 2 of 14 residents reviewed for choices in a sample of 15. (Resident # 53 and 54) Findings include: During the group interview on 12/6/11 at 2 p.m., Resident # 53 indicated she could not open her room windows because they had been "locked" and they would not open even a "small bit." During the environmental tour on 12/7/11 at 1 p.m., the window in Resident # 53's room was observed to have 2 screws blocking the movable window so the window would not open. At that time during interview, the Maintenance Director indicated he had been instructed to screw the windows so they would not open. He indicated the residents residing	F0151	I. Residents that were affected by the alleged deficient practice have been assessed by social service and no negative outcome has been identified. II. All residents have the potential to be affected by the alleged deficient practice. Maintenance and housekeeping have done a house wide	01/07/2012

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	in this room had the windows opened by the CNAs, and the open windows made the hallway and other room too hot and the air conditioning would freeze up. He indicated he had been asked to speak at a Resident Council meeting regarding this a few weeks ago. He also indicated no other resident room windows were screwed shut. On 12/7/11 at 3:30 p.m., during interview, Resident # 54 indicated that if she could change anything about her room, it would be the windows. She indicated the windows were bolted shut. She indicated the windows were open because the air conditioning in her room was not working this summer and fall. She indicated the Administrator was aware the air conditioning in her room was not working. She indicated she did not know the windows were bolted until she had asked a CNA to open the window and found it was "bolted" shut. She also indicated she could not go outside for air by herself. On 12/7/11 at 3:55 p.m., during interview, Resident # 53 indicated this past summer the air conditioning in her room was not working and her and her roommate opened their room windows. She indicated she had informed the Administrator. She also indicated she did		audit and no other windows have been identified to have any issues with opening, with the exception of the secured memory care unit. III. Staff have been re-educated on residents rights. Maintenance or designee will audit all windows one time a week for one month, and then monthly for four months. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed monthly	

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	not know the windows were locked until Resident # 54, her roommate, had told her. She indicated she had asked the Administrator to unlock the windows and he informed her that it could not be done because it would mess up the air conditioning. She indicated there was not a discussion with her regarding screwing the window shut or any other options given prior to the windows being screwed shut. During the daily exit on 12/7/11 at 4:30 p.m., during interview, the Administrator indicated that in October 2011 the reasons for screwing the window shut had been addressed with the Resident Council. He indicated the windows being open in that room caused problems with the air conditioning and with allergies for other residents. He indicated he had no documentation of any discussion with the above residents regarding screwing the windows shut or offering other solutions to the above stated problems. A 11/15/11 Resident Council meeting concern form indicated "...Windows screwed shut & (and) residents can't open for fresh air..." The note also indicated the council requested maintenance to attend the November 30 meeting to address issues. Resident # 54 was in attendance.		in QA meeting for 6 months and the quarterly with subsequent plan development and implementation as appropriate.	

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	A 11/30/11 Resident council meeting concern form indicated concerns from the previous meeting were addressed. The Administrator and Maintenance Director were in attendance in the meeting and addressed these issues. Resident # 54 was in attendance. A "Response to Resident Council Concern" November 15th, 2011 Meeting indicated "...3) Windows screwed shut and residents can't open for fresh air. a. This issue has multiple reasons for not being able to open the windows. i. In the summer when the air condition units are in operation when there are open windows and doors, the humidity comes in the windows goes into the air handling units in the attic and freezes the units up...When one resident enjoys the outside air that places three to five other resident rooms in jeopardy of having the air condition unit fail...ii This facility is a healthcare facility, not a residential facility. As of 11-21-11, we have 71 residents...64 percent of these resident have a diagnosis of respiratory disorder...When outside dust and pollen is placed into our facility environment it increases the chances of these residents becoming and being placed in distress...iii The facility provides year round access for residents to get fresh air....iv.			

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	Security...Even in this facility, in the past several years, outsiders have gained access form windows that have been left open..." A policy titled "Nursing Home Resident Rights" was provided by the Administrator on 12/5/11 at 10:50 a.m., and deemed as current. The policy indicated: "Basic Rights You have the right to be treated with respect and dignity in recognition of your individuality and preferences...Living Accommodations and Care Express preferences with respect to your room and roommate and be advised in writing before any changes are made...." 3.1-3(t) 3.1-3(u)(3)			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure dependent residents were fed in a manner to maintain or enhance their dignity for 1 of 1 dependent resident reviewed for dignity while dining in a sample of 15 (Resident #74) Findings include:	F0241	I. Resident #74 has been assessed by nursing and found to have no adverse effects from alleged	01/07/2012

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	Resident #74's record was reviewed on 12/5/11 at 3:37 p.m. Resident #74's current diagnoses included, but were not limited, Alzheimer's disease and anxiety. Resident #74 had a current,11/8/11, annual, Minimum Data Set assessment (MDS) which indicated the resident required staff assistance in order to eat. Resident #74 had a current, 3/4/11, care plan problem/need regarding nutritional risk. Approaches to this problem included, but were not limited to, encourage to consume 75% of meals; allow ample time to consume meals. During a 12/5/11, 11:40 a.m. to 12:35 p.m., lunch meal observation, CNA #6 fed Resident #74 her meal. While feeding Resident #74, the CNA did not speak to her, identify the food items, ask the resident to eat, make conversation or praise the consumption of food. CNA #6 spoke into her headset the entire meal. The CNA did not speak and instead tapped the spoon on the resident's lip to encourage the resident to eat. Examples of statements spoken by CNA #6 included, but were not limited to, "select room 718 bed one, go back, cancel, select		deficient practice. II. Residents who have assistance during meal time have the potential to be affected by the alleged deficient practice. Nurse aide #6 has been re-educated on customer service, Vocollect charting, resident rights, and proper feeding techniques. Nursing staff as been re-educated on the above same. III. DON or designee will monitor meal times on random shifts five times a week for one month, 3 times a week for one month, once a week	

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	room 715, ...yes 50, 240, select room, ...75, 240...bed 2." During an 12/5/11, 12:35 p.m., interview, LPN #7 indicated CNA #6 should have spoken to the resident and encouraged Resident #74 to dine. The CNA should not have been conversing with the headset, instead talked with the resident. Review of a current, facility policy titled "Eating Support", which was provided by the Director of Nursing on 12/8/11 at 12:48 p.m., indicated the following: "Never make the resident feel that a meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention..." 3.1-3(t)		for one month and monthly for 3 months. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	
F0252 SS=C	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to ensure the facility was clean and in good repair related to torn, cracked, and peeling drywall and paint, dirty floors, vents, toilets, windows, and shower rooms. This deficit practice had the potential to affect 73 of 73 residents	F0252	I. No residents were identified to be affected by this	01/07/2012

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	who reside in the building. Findings include: During the environmental tour on 12/07/11 at 1 p.m., with the Maintenance Director and the Environmental Services Director the following was observed. **200 and 400 Hallway:** The window at the end of the 200 hall had cob webs in the window sills. The floor in the corner at the fire doors on the 200 and 400 halls had a gray accumulation of dust and dirt. The 400 hall shower room's baseboard trim hand chipped paint and wood on the right and left wall. The 200 hall shower room first shower stall tiles on the floor had an orange discoloration and the grout was dark brown to black throughout. Room 209's toilet had a brown build up of soiling around the base. The window sills had cob webs in the corner. Room 417's bathroom doors on the inside were scratched with chipped wood 1/3 of the way up the doors.		alleged deficient practice. II. All residents have the potential to be affected by this alleged deficient practice. All areas identified have been assessed and cleaned or repaired by the housekeeping and maintenance staff. III. Maintenance and Housekeeping will audit the building and grounds randomly three times a week for one month, once a week for 3 months and monthly for 2 months to ensure proper cleaning and	

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	500 and 600 Hallway The floor in the corner at the fire doors on the 500 and 600 halls had a gray accumulation of dust and dirt. The 500 hall shower room had a privacy curtain that was off the 3 hooks at the ceiling, 2 of the 3 ceiling vents had a build up of dust. The privacy wall around the toilet had areas of broken plaster and paint 1/4 way up the wall. In the main dining room, 5 of 15 ceiling light fixtures had visible cob webs and all of them had a build up of dust. The floor around the wall by the fireplace had dust and cob webs. Room 514 had torn and peeling paint under the heating unit. **700 Hall** The 700 hall shower room entry door had chipped and broken wood from latch to floor. The shower stalls had a build up of an orange substance on the tiles around the walls and darkened grout. The floor in the corner at the fire door on the 700 hall had a gray accumulation of dust and dirt.		maintenance techniques have been established. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	

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	The ceiling outside room 710 and 711 had cracked plaster, the ceiling vent outside room 711 had an accumulation of dust. The dining room had debris scattered on the floor all throughout. The table under the television had an accumulation of dust. Room 715 had chipped paint by the 1st bed's nightstand and the floor around the toilet had a brown soiling. The window sill had cob webs. During the tour the Maintenance Supervisor indicated during interview, he would get started on the needed repairs. 3.1-19(f)			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, observation and interview, the facility failed to ensure the physician orders were followed regarding oxygen administration and the treatment of a pressure ulcers for 4 of 15 residents reviewed for following physician orders in a sample of 15. (Resident # 6, 28, 43 and 47)	F0282	I. Residents # 6, 28, 43 and 47 have been assessed by nursing and no adverse affects	01/07/2012

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	Findings include: 1. The record for Resident # 6 was reviewed on 12/5/11 at 3:30 p.m. Current diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease. Current physician orders for December 2011 indicated an order for oxygen to be administered at 2 liters daily. On 12/5/11 at 12 p.m., Resident # 6 was in his wheelchair in the hallway; his oxygen rate was set at 2.5 liters. At 3:20 p.m., the resident was in his wheelchair in his room; his oxygen rate was set at 2.5 liters. At 3:25 p.m., LPN # 2 was informed the oxygen was set at the incorrect rate. At that time, during interview, she indicated the resident should be on 2 liters of oxygen and she changed to flow rate to 2 liters. 2. The record for Resident # 28 was reviewed on 12/6/11 at 9:35 a.m. Current diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease.		have been identified by this alleged deficient practice. II. Residents with physician orders for oxygen administration or skin treatments have the potential to be affected by the alleged deficient practice. "Check for 02 rates", and "check for placement of dressing" have been added to the MAR/TAR to prompt nursing to verify and check placement. Nursing staff have been re-educated on administration of treatment and physicians orders.	

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	Current physician orders for December 2011 indicated an order for oxygen to be administered to maintain saturations greater than 90 % and to keep at 2 liters. On 12/5/11 at 5:30 p.m., the resident was in her wheelchair in the dining room. Her oxygen rate was set at 1.5 liters. At that time, LPN # 3 checked the flow rate and order and during interview, indicated the flow rate should be set at 2 liters.		III. DON or designee will monitor O2 rates and placement of dressings on random shifts 3 times a week for one month, once a week for two months, once a month for three months. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary actions as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as	

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	3. During the facility tour on 12/05/2011 at 10:08 A.M., Resident #47 was identified by LPN #1 as having no pressure ulcers. Resident #47 was observed on 12/07/2011 at 10:00 A.M., with LPN #1. His coccyx was observed. He had a 0.6 cm x 0.2 cm reddened ulcer on his left buttock. There was no dressing on the ulcer. LPN #1 touched the reddened the resident said "Ouch." LPN #1 indicated he had a treatment of Xenaderm only. She further said his coccyx "didn't look like that yesterday." Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M. Resident#47's diagnoses included, but were not limited to, Bi-Polar, chronic back pain, depression, confusion, and altered mental state. Review of the December 2011 physician's orders indicated an order for "Vasolex ointment i.e.. Xenaderm ointment. Apply to coccyx, c/w (cover with) Mepilex, change twice daily and as needed." Review of the December 2011 TAR (treatment administration record)		appropriate.	

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	indicated an order for "Vasolex ointment then Xenaderm to coccyx BID et prn soilage" had been completed as ordered. On 12/07/2011 at 10:05 A.M., the DON indicated "Yes, there should have been a dressing on his coccyx." 4. During the facility tour on 12/05/2011 at 10:05 A.M., Resident #43 was identified by LPN #1 as using oxygen. Resident #43's was observed on 12/7/2011 at 9:15 A.M. She had oxygen infusing via a nasal cannula. The rate was set at 1 L. LPN #1 observed the same and said Resident #43 should have her oxygen at 2L. She then changed the oxygen setting to 2 L. Resident #43's clinical record was reviewed on 12/06/2011 at 1:15 P.M. Resident #43's diagnoses included, but not limited to, COPD (chronic obstructive pulmonary disease), depression, hypertension, coronary heart disease, and a right hip fracture with an internal fixation. The resident's December 2011 physician's orders indicated the resident had an order originally dated 10/21/2011 for "Oxygen at 2L/min per NC (nasal cannula)."			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=D	3.1-35(g)(2) Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to prevent unstagable pressure ulcers for 1 of 3 residents with pressure ulcers and failed to ensure a treatment was in place for 2 of 3 residents with a pressure ulcers in sample of 15 (Residents #18, #43 and #47). Findings included: 1. During the facility tour on 12/05/2011 at 10:05 A.M., Resident #43 was identified by LPN #1 as having pressure ulcers to both of her heels. She indicated they had been caused by sheering. Resident #43 was observed with her right heel flat on the bed and the left foot on top of the right foot at the time of the tour. Resident #43's heels were observed on 12/7/2011 at 9:15 A.M. Her right heel	F0314	I. Residents # 18, 43 and 47 have been assessed by the nursing staff and no adverse affects have been identified by this alleged deficient practice. II. Residents with a diagnosis of open areas or pressure wounds have the potential to be affected by this alleged deficient practice. A review of current in house residents' medical record, that has treatment orders has been completed to identify any missing treatments and skin assessments. Physician has been notified if applicable. III. Nursing staff have been re-educated on facility expectations of following physicians' orders, administering treatments, documentation and pressure ulcer prevention. DON or designee will monitor treatment and placement of dressings on random shifts 3 times a week for one month, once a week for two months, once a month for three months. Staff non-compliance will be addressed	01/07/2012

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	155295	A. BUILDING 00 B. WING	12/08/2011

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	had a 6.0 cm. (centimeter) by 6.0 cm. dried black rounded area. The left heel had a 1.5 cm circular area on the inner aspect of the heel. Resident #43 was observed lying in her bed on 12/7/2011 at 3:00 P.M. Her heels were flat on the bed. There was a pillow under her knees. Resident #43's clinical record was reviewed on 12/06/2011 at 1:15 P.M. Resident #43's diagnoses included, but not limited to, COPD (chronic obstructive pulmonary disease),, depression, hypertension, coronary heart disease, and a right hip fracture with an internal fixation. Resident #43 was readmitted to the facility on 10/20/2011 at 6:30 P.M., post right hip fracture. Her readmission assessment indicated clear, intact skin on the resident's heels. The change of condition report for skin condition dated 11/1/11 at 2:00 P.M., indicated 3 areas of new onset of wounds located on "(R) inner heel 6 x 9 cm. blood filled intact blister, (L) outer heel 1.6 x 2.0 fluid filled c (with) 3 x 6 fluid filler c 3 x 6 surrounding, top of (R) foot 1 x 1.5 dark redness area c 5.0 x 9.0 redness		with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	

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	surrounding. The problem was an acute skin condition which was from pressure and friction." There was a notation at 3:30 P.M. of ".... These areas were not present yesterday...." The nurses' notes indicated on 11/1/11 at 3:40 P.M., "... Blisters to (L) (left) (R) (right) heels et top of (R) foot." The non-pressure skin condition report dated 11/1/11 indicated a friction blister had occurred on the resident's right inner heel. It was 6.0 cm by 9.0 cm with an undetermined depth. The description was "intact, blood-filled blister." The measurements on 12/1/2011 were 6.0 cm. by 6.0 cm. It was described as black, brown, eschar with no change. There was no drainage. The pressure ulcer evaluation record dated 11/1/11 indicated a friction blister had occurred on the resident's left outer heel. It was 1.6 cm by 2.0 cm. with an undetermined depth. The description was "deep tissue injury" but unable to determine the depth. The measurements on 12/1/2011 were 1.5 cm. by 1.5 cm. Review of the December 2011 physician's orders indicated an order for "Float heels off bed."			

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	Review of the December TAR (Treatment Administration Record) indicated an order for "Float heels off bed." The TAR indicated this treatment had been completed each shift on the dates of 12/1/11-12/7/11. Review of the Resident #43's quarterly MDS (minimum data set) assessment, dated 9/19/2011, indicated the resident needed extensive assistance of one person to move in bed. She was further assessed as having no pressure ulcers. The resident's clinical record lacked a skin assessment. As of the exit from the facility none was provided by the facility. Review of the resident's care plan indicated a care plan for "Skin integrity care plan: prevention" for the Potential for impaired skin integrity r/t (related to) impaired mobility dated 10/29/2011. The interventions included, but were not limited to, "pressure reducing mattress, encourage to reposition as able...." The care plan was updated on 11/5/11 with a notation of "fluid filled sac (sic) bilat (bilateral) heels," and on 11/6/11, "eschar (R) heel." There were no further updates to the care plan. During an interview with LPN #1 on 12/7/11 at 9:30 A.M., she indicated the			

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	resident's black heels had occurred due to shearing. 2. During the facility tour on 12/05/2011 at 10:08 A.M., Resident #47 was identified by LPN #1 as having no pressure ulcers. Resident #47 was observed on 12/07/2011 at 10:00 A.M., with LPN #1. His coccyx was observed. He had a 0.6 cm x 0.2 cm reddened ulcer on his left buttock. There was no dressing on the ulcer. LPN #1 touched the reddened the resident said "Ouch." LPN #1 indicated he had a treatment of Xenaderm only. She further said his coccyx "didn't look like that yesterday." Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M. Resident#47's diagnoses included, but were not limited to, Bi-Polar, chronic back pain, depression, confusion, and altered mental state. Review of the "Nursing Admission Assessment" dated 11/22/2011 indicated the resident was admitted with a stage II pressure ulcer to the coccyx measuring 2.0 cm (centimeter) x 1.8 cm. Review of the Braden Scale for predicting			

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	pressure sore risk indicated on 11/23/2011 the resident had a total score of 9. The key for the scale indicated a "Total score of 12 or less represents HIGH RISK. This was updated on 12/07/2011 with a total score of 12. Review of the physician's orders indicated an order dated 11/23/2011 "Xenderm (a topical ointment for the treatment of pressure ulcers) on coccyx BID (2 times a day) et cover c/ Mepilex (a dressing) BID and prn (as needed)." Review of the November 2011 TAR (treatment administration record) indicated an order for "Apply to coccyx: Xenderm et cover c/ Mepilex BID and prn soilage" had been completed as ordered. Review of the December 2011 physician's orders indicated an order for "Vasolex ointment i.e.. Xenaderm ointment. Apply to coccyx, c/w (cover with) Mepilex, change twice daily and as needed." Review of the December 2011 TAR (treatment administration record) indicated an order for "Vasolex ointment then Xenderm to coccyx BID et prn soilage" had been completed as ordered. The care plan for pressure ulcers dated 11/23/2011 for the problem of "Actual			

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	Pressure Ulcer on the coccyx indicated an intervention of "Treatment ordered Xenaderm and Meplix." Review of the Admission MDS (minimum data set) assessment dated 12/02/2011 indicated Resident #47 had no pressure ulcers. He was assessed as needing extensive assistance of two persons for bed mobility. On 12/07/2011 at 10:05 A.M., the DON indicated "Yes, there should have been a dressing on his coccyx." The clinical record had no additional measurements of the pressure ulcer. On 12/07/2011 at 10:50 A.M., the DON indicated there was no monitoring for the coccyx pressure ulcer in the clinical record. 3. The record for Resident # 18 was reviewed on 12/6/11 at 2 p.m. Current diagnoses included, but were not limited to, Multiple Sclerosis and Diabetes Mellitus. A "Pressure Ulcer Evaluation Record" indicated on 11/18/11 the resident had a stage II pressure ulcer on her coccyx measuring 1 centimeter (cm) by 1 cm. A physician order dated 11/18/11			

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	indicated an order for a Duoderm to sacral skin ulcer to be changed every 3 days and as needed until healed. On 12/5/11 at 4:45 p.m. during a care observation, the resident was in bed receiving care. When she was turned to her side, her coccyx was observed to have an open area red and yellow in color. No Duoderm was in place on the ulcer. After her care was completed, CNA # 4 applied Calazime cream to the coccyx area covering the ulcer. The resident was then dressed and gotten up in her wheelchair and taken to the dining room for dinner. At 5:50 p.m., LPN # 5 was informed the resident did not have a Duoderm on her coccyx ulcer and the CNA had applied Calazime to the ulcer area. At that time, during interview, the LPN indicated the resident should have a Duoderm and she thought the day shift nurse had completed this treatment. She indicated the CNA should not have applied at the Calazime over the ulcer. 4. A policy titled "Pressure Ulcer, Prevention of" was provided by the Director of Nursing on 12/8/11 at 12:48 p.m. and deemed as current. The policy indicated: "...Purpose To prevent skin breakdown and development of pressure sores...Procedure...1. Assess for risk of			

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	pressure ulcer development. a. Identify high and low risk residents...3. Develop care plan to eliminate or minimize risk factors...d. Pressure relief...7. Use appropriate support surface in the resident's bed and chair. 8. Use pressure reducing or relieving devices as necessary...11. Position with appropriate surfaces to protect bony prominence's...If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided...." 3.1-40(a)(1) 3.1-40(a)(2)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation and interview, the facility failed to ensure biologicals and razors were secured in a manner to prevent the possibility of injury. This deficit practice had the potential to affect 8 of 73 residents who identified as cognitively impaired and who can freely move about the facility. Findings include:	F0323	I. No residents were identified as affected by this alleged deficient practice. II. All	01/07/2012

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	On 12/8/11 at 1:40 p.m., the Administrator provided a list of 8 residents who were cognitively impaired and could move about freely. During the environmental tour on 12/07/11 at 1 p.m., with the Maintenance Director and the Environmental Services Director the following was observed. The activity room had a bottle of Softscrub with Bleach in the cabinet above the sink. The bottle had "...hazardous to humans..." written on it. At that time the Maintenance Director removed the Softscrub and indicated during interview, the Softscrub should be stored in the locked cabinets provided in the room. In the unlocked 500 hall shower room there were 20 plus blue safety razors, 2 bottle of mouthwash, 1 can of hair spray and a bottle of Virex disinfectant in the unlocked cabinet in the room. The cabinet had a lock and a key on the cabinet but they were not in use. At that time during interview, the Maintenance director indicated the cabinet should be locked with the lock and key provided. During interview on 12/8/11 at 9:30 a.m., the Administrator indicated hazards		residents have the potential to be affected by this alleged deficient practice. An audit of the building has been conducted and any materials that may be of hazard have been removed and or placed in locked enviroment. All staff have been re-educated on storing or locking of potentially hazardous materials. III. DON or designee will monitor units and storage areas on random shifts 3 times a week for one month, once a week for two months and	

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	should not be in unlocked areas. A material safety data sheet for Virex II was provided by the Administrator on 12/8/11 at 12:50 p.m. and deemed as current. The sheet indicated "...routes of entry Inhalation. Skin contact. Eye contact. Potential Acute Health Effects Eyes Corrosive. May cause permanent damage including blindness. Skin Corrosive. May cause permanent damage. Inhalation May cause irritation and corrosive effects to nose, throat and respiratory tract. Ingestion Corrosive. May cause burns to mouth, throat, and stomach...." 3.1-45(a)(1)		once a month for three months. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	
F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to ensure,	F0325		01/07/2012

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	a resident who required staff assistance to eat and was nutritionally at risk, was fed adequately by staff and given ample time to eat, and was offered replacements for poor consumption, for 1 of 1 resident reviewed for assistance to dine in a sample of 15 (Resident #74). Findings include: Resident #74's record was reviewed on 12/5/11 at 3:37 p.m. Resident #74's current diagnoses included, but were not limited, Alzheimer's disease and anxiety. Resident #74 had a current, 11/8/11, annual, Minimum Data Set assessment (MDS) which indicated the resident required staff assistance in order to eat. Resident #74 had a current, 3/4/11, care plan problem/need regarding nutritional risk due to Alzheimer's disease and the inability to self feed.. Approaches to this problem included, but were not limited to, encourage to consume 75% of meals; allow ample time to consume meals. During a 12/5/11, 11:40 a.m. to 12:35 p.m., lunch meal observation, CNA #6 fed Resident #74 her meal. While feeding Resident #74, the CNA did not speak to her, identify the food items, asks the		I. Resident #74 has been assessed by nursing and found to have no adverse effects from alleged deficient practice. II. Residents who have assistance during meal time have the potential to be affected by the alleged deficient practice. Nurse aide #6 has been re-educated on customer service, Vocollect charting, resident rights and proper feeding techniques. Nursing staff as been re-educated on the above same. III. DON or designee will monitor	

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	resident to eat, make conversation or praise the consumption of food. CNA #6 spoke into the headset the entire meal. The CNA did not speak and instead tapped the spoon on the resident's lip to encourage the resident to eat. Resident #74 ate very slowly. Resident #74 drank two glasses of chocolate milk. CNA #6 stated to an unidentified staff member "she likes to drink." At 12:22 p.m., Resident #74 continued to take very small bites and ate very slowly. CNA #6 did not speak to Resident #74 and began to move her tray off the table and fold up the napkin. During a 12/5/11, 12:22 p.m., interview, CNA #6 indicated she had stopped feeding Resident #74 because she had slowed down and wasn't eating much. Following the interview, the CNA was requested to continue to feed Resident #74. Resident #74 ate an additional approximately 20 bites. Following the 20 bites, Resident #74 had still eaten less than 25% of her meal. During a 12/5/11, 12:30 p.m., interview, when questioned regarding alternates being offered for low consumption, CNA #6 indicated she was new and didn't know what to do and believed Resident #74 could not have a drink style oral supplement because one did not come on		meal times on random shifts five times a week for one month, 3 times a week for one month, once a week for one month, and monthly for 3 months. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	

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	her tray. When questioned if she should ask the nurse, CNA #6 again said she was new and didn't know what to do. CNA #6 did not ask the nurse what should be done regarding Resident #74's low consumption. During a 12/5/11, 12:33 p.m., interview, LPN #7 said if residents have poor consumption, they could have a supplement and some residents have a supplement in the refrigerator. She indicated Resident #74 had a drink supplement in the refrigerator which could be offered. When requested to offer said supplement, LPN #7 offered Resident #74 the drink supplement, Resource. The resident then consumed 100% of the supplement drink. During an 12/5/11, 12:35 p.m., interview, LPN #7 indicated CNA #6 should have spoken to the resident and encouraged Resident #74 to dine. The CNA should not have been conversing with the headset, instead talked with the resident. Review of a current, facility policy titled "Eating Support", which was provided by the Director of Nursing on 12/8/11 at 12:48 p.m., indicated the following: "Never make the resident feel that a meal must be hurried, but that the procedure is pleasant. Give him/her your complete			

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	attention..." 3.1-46(a)(1) 3.1-46(a)(2)			
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review, observation and interview, the facility failed to ensure oxygen was administered at the physician ordered rate for 3 of 4 residents observed with oxygen in a sample of 15. (Residents# 6, 28, and 43) Findings include: 1. The record for Resident # 6 was reviewed on 12/5/11 at 3:30 p.m. Current diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease. Current physician orders for December 2011 indicated an order for oxygen to be administered at 2 liters daily.	F0328	I. Residents # 6, 28 and 43 have been assessed and found no adverse affects have been identified by this alleged deficient practice. II. Residents who have physician orders to have oxygen administered have the potential to be affected by the alleged deficient practice. A review of those residents who have O2 orders has been conducted, and that any change of condition has been reported to the physician. III. Nursing staff have been re-educated on facility expectations of following physicians' orders, administering treatments and documentation. DON or designee will monitor treatment and O2 rates on random shifts 3 times a week for one month, once a week for two months, once a month for three months. Staff non-compliance will	01/07/2012

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	On 12/5/11 at 12 p.m., Resident # 6 was in his wheelchair in the hallway; his oxygen rate was set at 2.5 liters. At 3:20 p.m., the resident was in his wheelchair in his room; his oxygen rate was set at 2.5 liters. At 3:25 p.m., LPN # 2 was informed the oxygen was set at the incorrect rate. At that time, during interview, she indicated the resident should be on 2 liters of oxygen and she changed to flow rate to 2 liters. 2. The record for Resident # 28 was reviewed on 12/6/11 at 9:35 a.m. Current diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease. Current physician orders for December 2011 indicated an order for oxygen to be administered to maintain saturations greater than 90 % and to keep at 2 liters. On 12/5/11 at 5:30 p.m., the resident was in her wheelchair in the dining room. Her oxygen rate was set at 1.5 liters. At that time, LPN # 3 checked the flow rate and order and during interview, indicated the flow rate should be set at 2 liters. 3. Resident #43 was observed on 12/7/2011 at 9:15 A.M. She had oxygen		be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	

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	infusing via a nasal cannula. The rate was set at 1 L. LPN #1 observed the same and said Resident #43 should have her oxygen at 2L. She then changed the oxygen setting to 2 L. Resident #43's clinical record was reviewed on 12/06/2011 at 1:15 P.M. Resident #43's diagnoses included, but not limited to, COPD (chronic obstructive pulmonary disease), depression, hypertension, coronary heart disease, and a right hip fracture with an internal fixation. The resident's December 2011 physician's orders indicated the resident had an order originally dated 10/21/2011 for "Oxygen at 2L/min per NC (nasal cannula)." 4. A policy titled "Oxygen Administration" was provided by the Nurse Consultant on 12/7/11 at 9 a.m. The policy indicated: "...Procedure 1. Check physician's order for liter flow and method of administration...5...e. Set the flow meter to the rate ordered by the physician. 3.1-47(a)(6)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to ensure residents were not restarted on antipsychotic medications without significant episode of maladaptive behaviors; non-chemical interventions were attempted prior to the administration of as needed psychoactive medications; and residents who received antipsychotic medications had a current diagnosis for use, identified behavioral indicators for use, and a method to track behaviors which were being treated by the medication, for 3 of 7 residents reviewed for psychoactive medication use in a sample of 15 (Resident #49, #44 and #6).	F0329	I. Residents # 6, 44 and 49 have been assessed by the nursing staff and change of condition was reported to the Primary Care Physician. II. Residents who have	01/07/2012

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	Findings include: 1. Resident #49's record was reviewed on 12/7/11 at 2:00 p.m. Resident #49's current diagnoses included, but were not limited, Tourettes syndrome and dementia with behavioral disturbances. Resident #49 had a current order, which originated 10/01/10, for resident may be seen by psychiatrist. Resident #49 had a current, 10/25/11, quarterly, Minimum Data Set assessment (MDS) which indicated the resident was not displaying maladaptive behaviors during the assessment period. Resident #49 had a 7/13/11, psychiatry progress note which indicated the antipsychotic medication, Haldol, would be discontinued. Resident #49 had an 11/16/11 psychiatry progress note which indicated the following: "SSD [social service director] reports [increased] agitation/angers easily, will yell @ peers when upset. He will look anxious & can be intrusive...no overt hallucinations, no risk for self harm... Dose reduction is indicated at this time...		diagnosis of psychotic behaviors and are treated with antipsychotic medications have the potential to be affected by this alleged deficient practice. Those residents who currently receive antipsychotic drugs have been reviewed for behavior monitoring and the necessity of antipsychotic drug use. Nursing staff and Social Service department have been re-educated on the “Behavior Monitoring Program”, and use of antipsychotic drugs,	

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	D/C [discontinue] Celexa [antidepressant], [increase] Depakote [an anti-seizure medication used as a mood stabilizer]..." Resident #49's "Behavior/Intervention Monthly Flow Record" for November and December (1 through 7) 2011 were reviewed. Resident #49 was being monitored for verbal aggression, physical aggression and anxiety. Resident #49 displayed 1 episode of physical aggression during the 37 day period. Resident #49 had 5 episodes of verbal aggression during the 37 day period. The clinical record lacked any documentation regarding the verbal aggression having negatively impacted the resident's quality of life or the quality of life of others. Resident #49 had a 12/5/11, 12:00 p.m., social progress note which indicated, while he was in the dining room, Resident #49 had struck a peer on the arm. A nurse was able to remove the resident from the area and walked with him in the hall. "After a few minutes res [resident] was calm and returned to dining room. Res finished lunch without further conflict." Resident #49 had a 12/5/11, 12:45 p.m., physician's order for Haldol 6.5 mg (antipsychotic medication) two times daily. This order was obtained from the		assessments, interventions and documentation. III. Social Service/DON will audit for new antipsychotic drug use each morning in clinical meeting 5 times a week. Social Service will randomly audit behavior monitoring documentation, assessment and interventions 5 times a week for one month, 3 times a week for the following month, weekly for the next four months. Staff non-compliance will be addressed with 1:1 education and	

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	resident's primary physician. The clinical record lacked: a.) A second attempt to obtain a physical/medical assessment of the resident following his refusal post event. b.) An assessment of possible contributing factors to the behavioral outburst prior to restarting an antipsychotic medication. c.) Indication the psychiatrist, who was monitory psychoactive medications and behavioral symptoms, was involved in the decision making for treatment following the, 12/5/11, behavioral outburst when the resident calmed quickly thereafter. During an 12/7/11, 4:00 p.m., interview the Director of Nursing indicated the resident had a urine culture and no other form of assessment after the 12/5/11 behavior outburst. She indicated the resident calmed very quickly following the event. She indicated the facility did not wait for the results of urinary culture before re-starting the antipsychotic medication. She indicated the psychiatrist was not involved in the decision to re-start Resident #49's Haldol. 2. Resident #44's clinical record was reviewed on 12/6/2011 at 12:43 P.M.		progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	

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	Resident #44's diagnoses included, but were not limited to, acute respiratory failure, pneumonia, hypokalemia, malnutrition, hypertension, and dementia. Resident #44's December 2011 physician's orders indicated an order originally dated 11/25/11 for olanzapine (Zyprexa) (antipsychotic) 5 mg (milligram) give 1 tablet ... once a day." The November 2011 behavior documentation and December 2011 behavior documentation was reviewed for documented behaviors. This documentation lacked any monitoring of behaviors. During an interview with LPN #12 on 12/06/2011 at 2:14 P.M., she indicated there was no documentation of the behaviors, but there should have been. She further indicated there was no care plan related to the use of the olanzapine. Resident #44's diagnoses did not have a documented diagnosis for the use of the olanzapine. During an interview with the DON on 12/06/2011 at 3:30 P.M., she indicated the resident had a diagnosis for the use of the olanzapine when she was a resident the last time she was here, but it had not been carried over onto this chart.			

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	3. The record for Resident # 6 was reviewed on 12/5/11 at 3:30 p.m. Current diagnoses included, but were not limited to, dementia. Current physician orders for December 2011 indicated an order for Xanax 0.25 milligrams orally two times daily as needed for agitation. Original date of order was 10/10/11. The October Medication Administration Record for October 2011 indicated the resident was given Xanax 0.25 milligrams on 10/10, 11, 12, 13, 14, 15, 18, 29, and 31, 2011. No indication for use was identified. Additional information was requested on 12/6/11 at 3:25 p.m., from the Director of Nursing regarding prior interventions and behaviors for the use of the Xanax. On 12/7/11 at 10:50 a.m., the Director of Nursing indicated there was no behaviors or prior interventions for the use of the Xanax. She indicated the Xanax was being given for a "sleeper." 4. A policy titled "Psychoactive Medication Management" was provided by the Nurse Consultant on 12/7/11 at 9 a.m., and deemed as current. The policy indicated: "...Policy It is the policy of this facility that residents in need of psychotherapeutic medications receive appropriate assessment and interventions in order to achieve their highest practicable level of functioning, that residents with mental illness receive the necessary treatment to enable or restore their function,...Procedure...3. When psychoactive medications are prescribed for a specific condition	F0329	I. Residents # 6, 44 and 49 have been assessed by the nursing staff and change of condition was reported to the Primary Care Physician. II. Residents who have diagnosis of psychotic behaviors and are treated with antipsychotic medications have the potential to be affected by this alleged deficient practice. Those residents who currently receive antipsychotic drugs have been reviewed	01/07/2012

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	or targeted behavior, the clinical record will be reflective of the diagnosis, reasons for use,...and have a care plan in place with medication use and non-drug interventions that had been attempted to alleviate the condition. The effectiveness of these medications and non-drug approaches should be regularly documented in the nurses' notes...Psychoactive drugs may be ordered on a PRN (as needed) basis and should have a very clear and specific indications for use. Special attention should be given to attempt non-drug approaches outlined in residents' plan of care prior to using a PRN medication to control behavior or promote sleep...8. Medication effects will be monitored and documented on the medication administration record, to include targeted behavior monitoring, and monitoring for adverse effects when the medication are used....." 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5)		for behavior monitoring and the necessity of antipsychotic drug use. Nursing staff and Social Service department have been re-educated on the "Behavior Monitoring Program", and use of antipsychotic drugs, assessments, interventions and documentation. III. Social Service/DON will audit for new antipsychotic drug use each morning in clinical meeting 5 times a week. Social Service will randomly audit behavior monitoring	

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			documentation, assessment and interventions 5 times a week for one month, 3 times a week for the following month, weekly for the next four months. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	

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F0425 SS=E	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to remove and destroy expired insulin for 4 of 22 vials of insulin observed which impacted 1 of 1 resident in a sample of 15 and 3 of 3 residents in a supplemental sample of 13 with expired insulin (Residents #3, #4, #18, and #27). Findings included: 1. During the medication observation on 12/05/2011 at 11:10 A.M. with LPN #14, the following was observed in the medication room refrigerator: Resident #18 had a bottle of Lantus insulin dated with a do not use after date of 11/ 30/2011.	F0425	I. Residents # 3, 4, 18 and 27 were assessed for any adverse affects from alleged deficient practice with any findings reported to the physician. II. Residents with the diagnosis of Diabetes have the potential to be affected by the alleged	01/07/2012

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	Resident #27 had a bottle of Novolog insulin dated with a do not use after date of 11/29/2011. Resident #3 had a bottle of Humalog insulin dated with a do not use after date of 12/02/2011. Resident #4 had a bottle of Lantus with an open date of 10/19/2011. LPN #14 indicated the 4 bottles of insulin where in use, but they were outdated and needed to be destroyed. She then retrieved 4 new bottles of insulin for these residents. Review of the policy for undated policy for "Maximum Storage Conditions for Insulin Vials" provided by the Nurse Consultant on 12/08/2011 at 4:45 P.M., indicated all vials of insulin when opened were expired after 28 days when stored in the refrigerator at 36-26 degrees F. 3.1-25(o)		deficient practice. An audit of the medication carts was conducted. Nursing staff have been re-educated on the policy and procedure of medications and expiration dates. III. DON or designee will monitor all medication carts for expired meds 5 times a week for one month, 3 times a week for one month, once a week for one month, then monthly for 3 months. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed.	

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			IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	

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F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	A. Based on record review and interview, the facility failed to implement an infection control program which included tracking, trending, and follow up concerning any infectious patterns. This	F0441	I. No negative outcome	01/07/2012

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	deficient practice had the potential to impact 73 of 73 residents. B. Based on observations, interview, and record review, the facility failed to ensure infection control practices were implemented and followed in a manner to prevent the potential for the spread of infections and diseases during personal care for 1 of 2 residents observed for personal care in a sample of 15 (Resident # 18) (CNA # 4), and failed to ensure isolation procedures were implemented for 1 of 1 resident reviewed for isolation in a sample of 15 (Resident # 43), and failed to ensure handwashing in the dining room was completed when indicated for 4 of 4 residents reviewed in a supplemental sample of 13. (Resident # 48, 58, 16, and 45) (CNA # 8, 9, and 10) Findings include: A1. On 12/6/11 at 3 p.m., the Director of Nursing provided the infection control program, including her tracking and trending, and this information was reviewed at this time. The information included a laboratory print out of residents with urinary tract infections and bowel infections. Facility layouts were provided for July, August, September, October and November 2011 with room numbers highlighted to indicate rooms with urinary		was identified through observation or assessment for the alleged deficient practice. II. All residents have the potential to be affected by the alleged deficient practice. A review of those residents currently being treated for an infection and no trends were identified. Nursing staff has been re-educated on the Infection control policy, hand washing, isolation procedures, transporting linens, ice passing. DON/ADON has	

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	155295	A. BUILDING 00 B. WING	12/08/2011

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	tract infections. No other infections were identified. At 3:45 p.m., during interview, the Director of Nursing indicated she had provided all the infection control information she had. When queried, she indicated there were no other infections in the building during the above time frame. At this time, she was asked to supply a pharmacy print out of all antibiotics for the last 3 months. On 12/7/11 at 4 p.m. a pharmacy print out was provided for all antibiotic therapies during the above time frame. The print out indicated there were 22 residents prescribed antibiotic therapy for upper respiratory, pneumonia, bronchitis, eye, cellulitis and wound infections. These infections were not identified as infections or tracked and trended. On 12/8/11 at 9:10 a.m., during interview, the Director of Nursing indicated there was not formal tracking of infections until November 2011. She indicated there is a board in the conference room that the management team looked at daily to see who was on current antibiotics and she knew where the residents were located and tracked infections in this manner. A policy titled "General Infection Control		implemented a program to be able to track and trend all infection as per policy. III. DON or designee will monitor randomly Hand washing, Ice pass, linen transport daily for one month, 3 times a week for one month, weekly for one month, and then monthly for 3 months. DON will monitor tracking and trending weekly. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results	

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	Policies" was provided by the Director of Nursing on 12/6/11 at 3 p.m., and deemed as current. The policy indicated: "...Infection surveillance will be either "whole house"... or "targeted" toward high risk/high volume, whichever is in accordance with local and state department of health requirements...." B.1. During a personal care observation on 12/5/11 at 4:45 p.m., with Resident # 18, CNA # 4 with gloved hands applied Calazime ointment to the resident's coccyx and gluteals, then removed her gloves and washed her hands for less than 8 seconds. She donned gloves and assisted CNA # 13 to transfer the resident into her wheelchair. CNA # 4 then removed her gloves and washed her hands for less than 5 seconds and removed the resident's oxygen tubing from the concentrator and placed it onto the portable tank. B. 2. During the facility tour on 12/05/2011 at 10:05 A.M., Resident #43 was identified by LPN #1 as being on an antibiotic. There were no signs on the door nor was there any personal protective equipment outside or inside the room. On 12/06/2011 at 10:30 A.M., there were no signs on the door nor was there any personal protective equipment outside or inside the room.		will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	

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On 12/07/2011 at 9:15 A.M., there was a sign on the door indicating the resident was on contact precautions, but there was no personal protective equipment outside or inside the room.

Resident #43's clinical record was reviewed on 12/06/2011 at 1:15 P.M.

Resident #43's diagnoses included, but not limited to, COPD (chronic obstructive pulmonary disease),, depression, hypertension, coronary heart disease, and a right hip fracture with an internal fixation.

Resident #43 was readmitted to the facility on 10/20/2011 at 6:30 P.M.

Review of the nurses' notes indicated:
11/28/11 at 10:15 P.M., "... Bowels loosely (sic) foul smelling. MD made aware. New order check for C-Diff...."
11/30/11 at 5:00 P.M. "N.O. rec'd (received) for Flagyl (an antibiotic) mg. (milligrams) P.O. (by mouth) BID X 14 days for C. diff...."
12/7/2011 1:00 A.M. "... Universal precautions continue. loose stool x 1 this shift...."

Resident #43's physician's orders indicated on 11/3011 "Flagyl 500 mg.

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	(milligrams) i (one) PO (by mouth) BID (2 times a day) x 14 days. Then re-check stool for C. Diff. During an interview with LPN #1 on 12/06/2011 at 2:30 P.M., she indicated the facility was using universal precautions for the resident's C.diff infection. During an interview with the Nurse Consultant on 12/7/2011 at 9:20 A.M., she indicated the resident should have been in contact isolation and there should have been a sign on the door. B. 3. During the noon meal observation on 12/05/2011 starting at 11:40 A.M., the following was observed: 11:47 A.M., CNA #8, removed the ice scoop, which was submerged in the ice bucket to include the handle, from the ice bucket and scooped the ice into the glass, filled it with water, and took the water to a resident. 11:50 A.M., CNA # 9 removed the ice scoop, which was submerged in ice, from the ice bucket, and scooped the ice into the glass, filled it with water, and took the water to a resident. 12:00 P.M., CNA #10 picked up a fork from the floor which Resident #48 had dropped on the floor. She took the fork back to the kitchen and returned with a set of silverware and handed them to			

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	Resident #48. CNA #10 then returned to the kitchen and got a meal for Resident #58 and then took the meal to the resident. She opened the butter, took the knife, and buttered the bread for the resident. She then gave the silverware to the resident. She returned to the kitchen window for food. She took the plate of food to Resident #16. She took the silverware, buttered her bread, gave her the silverware, placed her napkin in her lap, pushed her wheelchair up to the table. CNA #10 returned to the ice container, removed the scoop from inside the ice container, filled a glass with ice, returned the ice scoop to the container, and filled it with water. She took the glass of water to Resident #45. She then took a tray of food out of the dining room to a resident's room. She returned to the dining room and used alcohol gel before her next task. 12:15 P.M. CNA #11 removed the ice scoop, which was submerged in ice, from the ice container, filled a glass with the ice, returned the scoop to the ice container, filled the glass with water and took it to a resident. During an interview with the Administrator on 12/8/2011 at 9:30 A.M., he indicated the facility did not have a policy for the use and storage of the ice scoop.			

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	B. 4. Review of the policy for undated isolation policy provided by the Nurse Consultant on 12/7/2011 at 9:00 A.M., indicated "It is the policy of this facility to prevent the spread of infection within the facility through the use of isolation precautions. The 1996 Center for Disease Control Guidelines for isolation Precautions will be utilized in this facility.... Procedure for Isolation.... 3. Contact Precautions: In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident -care items....noncompliant behaviors with stool.... resident has very poor personal hygiene.... Clostridium difficile.... A. Obtain table/cart for 24 hour supply of masks, gowns, etc. needed to maintain isolation.. B. Obtain appropriate signage and post outside the door frame.... Handwashing it the single most important precaution to prevent the transmission of infection from one person to another...." B. 5. Review of the undated policy for "Hand Hygiene Process Measures" provided on 12/08/2011 at 4:00 P.M., by the DON. The policy indicated "Health care workers, visitors and volunteers must			

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	wash their hands with soap and water: before eating, after using the bathroom, when visibly soiled with dirt, after unprotected (ungloved and damaged gloves) contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, intact skin soiled with blood and other body fluids, wound drainage and soiled dressings, after contact with intact and non-intact skin, clothing and environmental surfaces or residents with new onset diarrhea even if gloves area worn. When forearms have prolonged contact (turning, lifting, moving, etc.) with the resident's skin, bed clothes, etc.) 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(j) 3.1-18(l)			
F0465 SS=C	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a soiled utility room was clean for 1 of 3 soiled utility rooms observed and failed to ensure 2 of 3 activity storage closets were clean. This deficient practice had the potential to affect 73 of 73 residents who reside in the building. Findings include:	F0465	I. No negative outcome was identified through observation or assessment for the alleged deficient practice.	01/07/2012

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	During the environmental tour on 12/07/11 at 1 p.m., with the Maintenance Director and the Environmental Services Director the following was observed. The soiled utility room on the 500 hall had 2 sets of bed bolsters, 2 floor mats, an air mattress, and a toilet seat riser on the floor. In the activity room, 2 of 2 storage closets had boxes, totes and other various items on the floor and there was visible debris scattered on the floor and dust. During interview, during the tour, the Maintenance Supervisor indicated the above area should be clean. 3.1-19(f)		II. All residents have the potential to be affected by the alleged deficient practice. All areas identified have been assessed and cleaned or repaired by the housekeeping and maintenance staff. III. Maintenance and housekeeping will audit the building randomly three times a week for one month, once a week for 3 months and monthly for 2 months to ensure proper cleaning and maintenance techniques have been established. Staff non-compliance will	

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			be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	